Concordia-Health
Official Legal Address
1901 Pennsylvania Avenue NW
Washington, DC 20006
United States
www.concordia-health.org

# REQUEST FOR AUTHORIZATION TO RETURN TO PART-TIME WORK DURING A PERIOD OF DISABILITY (SELF-EMPLOYED MEMBERS)

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**Important – Please read this information before completing the form.**

**What is the purpose of this form?**

You must complete this form if you wish to return to part-time work while you are receiving disability benefits.

This includes:

- returning to the self-employed activity you performed before your disability began;
- starting a new self-employed activity;
- returning to work as an employee;
- engaging in any other paid or unpaid activity that is compatible with your medical condition.

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**Where should you submit this form?**

Please complete this form and submit it to **Concordia Health** using your preferred submission method.

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**When should you submit this form?**

You must submit this form no later than the first business day before your return to work.

Failure to submit your request on time may result in a **10% reduction of your disability benefits** or the **denial of benefits**, in accordance with the Mutual Aid Program's rules governing the receipt of disability benefits while performing an authorized work activity.

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**Important**

This form is a request for authorization.

Before returning to part-time work, you are strongly encouraged to obtain written authorization from the **Concordia Health Medical Advisor**.

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**Exception**

If you continue an activity that began before your disability and remains compatible with your medical condition, you must notify **Concordia Health** within **30 days** after your disability has been reported.

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**Documents to attach**

If you are returning to work as an employee, please attach a copy of your employment agreement.

If your employment agreement is not yet available, please submit it as soon as it becomes available.

If you need assistance completing this form, please contact **Concordia Health Member Services**.

**REQUEST FOR AUTHORIZATION TO RESUME PART-TIME WORK DURING A PERIOD OF DISABILITY**

**Please complete this form if you wish to resume part-time work while continuing to receive disability benefits.**

This form must be completed if you are:

- returning to part of the work you performed before your disability began; or
- returning to a different work activity that is compatible with your medical condition.

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**MEMBER INFORMATION**

**First Name:** _____

**Last Name:** _____

**Address:** _____

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**Member ID Number:** _____

**Email Address:** _____

**Mobile or Phone Number:** _____

I hereby request authorization from the **Concordia Health Medical Advisor** to resume part-time work beginning on:

**Effective Date:** ____ /____ /_____

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**1. Please indicate the type of work activity.**

☐ **Self-employed**

- ☐ Returning to the self-employed activity you performed before your disability began
- ☐ Beginning a different self-employed activity

☐ **Employee**

- ☐ Returning to your previous employer
- ☐ Returning to a different employer

☐ **Volunteer**

☐ **Other activity**

- ☐ Paid activity
- ☐ Unpaid activity

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**2. Please describe the work you will perform.**

Please describe all duties and responsibilities as accurately and completely as possible.

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**3. Please provide your work schedule.**

☐ **I work a variable schedule** (my working hours are not fixed).

**Number of hours worked per week under the approved part-time work arrangement:**

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☐ **I work a fixed schedule.** My weekly work schedule is provided below.

If your work schedule is the same each week, please complete **Week 1 only**.

**Number of hours worked per week under the approved part-time work arrangement:**

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**Weekly Work Schedule**

| | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|---|---|---|---|---|---|---|---|
| **Week 1** | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| **Week 2** | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| **Week 3** | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| **Week 4** | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |
| | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ | From ____<br>To ____ |

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**Additional Information**

Please provide any additional information that may help us understand your work schedule.

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**4. Please complete the information below.**

**Employer or Organization Name** *(complete this section only if you are not self-employed)*

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**Address**

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**Phone Number**

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**Employer Identification Number (EIN)**

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**Important**

An **Employer Identification Number (EIN)** is required, when applicable, to process your request.

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**Additional Information (if available)**

**Primary Care Provider**

**Name:** _____

**Address:** _____

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**Phone Number:** _____

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**Occupational Health Provider** ***(if applicable)***

**Name:** _____

**Address:** _____

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**Phone Number:** _____

**Declaration**

I certify that the information provided in this application is true, complete, and accurate.

**Date:** ____ /____ /_____

**Signature:** _____

**Data Protection Notice**

Concordia Health processes your personal data in accordance with applicable data protection and privacy laws.

You have the right to:

- access your personal data
- request correction or completion of your data
- object to certain types of processing
- request restriction of processing
- request deletion of your data, where applicable

For more information about how your data is processed, please refer to our **Data Protection Policy**, available at the following address:

https://www.concordia-health.org/terms-of-use

End of Form – CH-PTR-001 (v1.0)